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by Laparotomy

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REPORT OF A CASE OF ABDOMINAL PREGNANCY TREATED BY LAPAROTOMY.

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New York.

ALTHOUGH the serial literature of medicine has contained numerous contributions to the subject of extra-uterine pregnancy, until a very recent period this has been scattered, uncollated, and difficult of access. The experience and views of individuals have there been recorded, but deductions based upon a systematic and thorough comparison of results, and a careful study of the natural history of these grave cases, have been impossible.

About a year ago, Dr. John S. Parry, of this country, published a work which had for its foundation the examination of five hundred recorded cases of this character, from which he drew his deductions so logically, dispassionately, and fairly, that although his work has been for so short a period before the profession it does not appear to be premature to assert that it offers itself as a safe guide for practice. This production, replete with evidences of industry, research, and scholarly attainments, was the last contribution which its gifted author was destined to make to science, for soon after its appearance his death occurred.

An examination of the material which he has placed so abundantly at our disposal will show how important is early and certain diagnosis. In many cases which have ended fatally, a successful issue might have been attained by recognition of the dangerous condition and a resort to the resources of surgery. A fatal issue has very commonly occurred before even a suspicion has been entertained as to the true nature of the case. And in a number of cases by

no means small, the lives of women, and even of children, have been preserved by prompt interference based upon certain diagnosis.

With the improved means of diagnosis now at our disposal, it is certainly highly probable that a large proportion of such cases as those which have heretofore ended fatally, may in the future be saved from death by the aid of science.

I would not have it supposed that I would advocate a uniform resort to surgical interference, even after a certain diagnosis of extra-uterine pregnancy has been arrived at. This is by no means the position which I would assume. Cases will be met with in which such interference would be highly reprehensible; others will be seen in which inaction and non-interference would constitute a crime. The conscientious practitioner will be guided here as elsewhere by the dictates of his judgment carefully and thoughtfully arrived at. He will be glad to dispense with the knife, yet courageous enough to assume any, even the gravest, responsibility in its use, when convinced that duty prompts it in the interest of the lives entrusted to his keeping.

The case which I shall now report is offered as a contribution to this interesting and important subject.

On the 13th of April, 1876, Dr. James Hadden of New York sent to me for examination Mrs. R., aged 26 years, a native of New York State, who had been married six years, and had had one child, now five years old, and two abortions, one four years, and the other two years ago.

No peculiarities had developed in connection with the pregnancy or labor of five years ago, except that during the former she had menstruated regularly with the exception of one month, and that after the latter she had suffered from an attack of puerperal fever, which had confined her to bed for six weeks.

Seven months before the date here given she began to suffer from nausea and vomiting, and very soon after this time she had two or three attacks of intestinal trouble, which were marked by severe pain, nausea, retching, purging, and tympanites. At her menstrual epochs, metrorrhagia

now developed itself. Movement always tended to develop these unpleasant symptoms, or to increase them if they already existed.

About this period Mrs. R. declares that she distinctly felt the movements of a child in her abdomen, which was quite enlarged, and came to the conclusion that she was pregnant. As a number of obscure symptoms existed, she called on Dr. Hadden, who agreed with her in her surmise, and fixed the term of pregnancy at about three and a half months.

During February she had very distinct "bearing down pains," and at that time it was thought that labor would come on in a few days. At this time she had intense back-ache, and pains in the side and abdomen. Sometimes these were continuous, at others intermittent. They were often so severe that morphia was administered for their relief.

Upon her visit to me, April 13th, 1876, the patient was much emaciated; her temperature $101\frac{1}{2}$ to 102 towards night; the surface was dry during the day, but profuse perspirations occurred every night; and the eyes presented that peculiar brightness so commonly noticed in hectic fever. At this time she was convinced that she had been in error as to her pregnancy, yet whenever she referred to the subject of her recognition of the fetal movements, she did so as one does who is convinced against her own convictions.

Upon examination, I found* that she presented an abdominal tumor as large as that created by the uterus at the full term of pregnancy. It yielded superficial fluctuation everywhere, no solid element appearing at any point, and everywhere over its surface percussion evidenced complete dullness. The linea alba was rendered dark by deposits of pigment, and the skin of the abdomen showed where great distention had created *liniæ albicantiæ*.

Upon vaginal examination, the uterus was found anteverted, and I was much surprised to discover that it, as well as the other viscera of the pelvis, was fixed as if by an old attack of pelvic peritonitis. With some difficulty, and a great deal of care, I passed a small uterine probe to the

fundus, and found that the length of the uterine cavity was three inches and a half, perhaps a little more, but this was all that I attained to.

The patient, although, as I have stated, thoroughly convinced that she was not pregnant, and fully persuaded that she had an ovarian tumor, seemed so clear in her declaration and description of fetal movements in the earlier periods of her illness, that I examined the mammæ very carefully, and discovered in darkened areolæ and hypertrophied glands evidences which decided me upon removing a large amount, if not all, of the fluid in the tumor before committing myself to a diagnosis.

Accordingly, upon the 22d of April, I removed, by the aspirator of Dieulafoy, four quarts of a sero-purulent fluid, which contained albumen in large quantities, and resembled very closely fluid from an ovarian cyst; the walls of which have undergone inflammatory action. This, being submitted for examination to an excellent microscopist, was declared by him to present corpuscles which he believed to be ovarian.

I should have removed a larger amount of fluid, but when this had been withdrawn no more would flow. Believing that I had taken enough to enable me to make a complete chemical and microscopic examination, I withdrew the needle, and found that the flow had been checked by obturation of the canula by means of a pellet of white and dense lymph.

Palpation of the tumor now revealed the presence of a large, solid mass within it, which was so movable that it could be rolled from side to side, and conjoined manipulation showed the uterine body fixed at the symphysis pubis, and somewhat larger than normal.

I now made a positive diagnosis of abdominal pregnancy, and expressed the conviction, from which I never subsequently wavered, that the fetus floated freely in a mass of sero-pus in the peritoneal cavity, that the pelvic roof was covered by a mass of consolidated lymph, and that the intestines, pressed toward the flanks, had been covered over and fixed there by the same material. This position I felt

sustained in by the following facts: 1st, the existence of nausea and vomiting during the early months of the patient's illness, which disappeared, giving place to; 2d, distinct fetal movements, about which the patient was so clear and confident that I could not divest my mind of a belief in their possible validity; 3d, the presence of a marked pigimentary deposit in the linea alba and areolæ of the breasts; 4th, the presence of an enlarged though empty uterus, fixed, as were all the pelvic viscera, yet without evidences of pelvic peritonitis; and, 5th, the existence of a large, solid body, which rolled around freely in the cavity of the abdomen. There may be those who will say that these evidences were too meagre for diagnosis. All that I have to say in reply is, that I thought otherwise, and had confidence in my belief.

The patient's family was informed of my conclusion, and gladly accepted the alternative of operation, as it was quite evident to them that death would be the inevitable result of further delay. The patient herself was left under the impression that ovariectomy was to be performed.

On the 10th of May, I operated, at 3 P. M., at the residence of the patient, and in the presence of Dr. Dusinger, of Lockhaven, Penn., and Drs. Jas. B. Hunter, H. F. Walker, Chas. S. Ward, S. B. Jones, and James Hadden, of New York.

The patient having been etherized, an incision was made extending from the symphysis pubis five inches upwards towards the umbilicus, and carried down to the peritoneum. Had I been operating without a firm belief in the diagnosis of abdominal pregnancy, and under an impression that an ovarian tumor existed, I should at this point have, I feel sure, been led into an error which would have lost my patient's life. The peritoneum was so much hypertrophied that I should have peeled it off from its apparently loose attachment to the abdominal walls, under the impression that it was an adherent ovarian cyst. Cutting through it, a large amount of such fluid as I have described as removed by aspiration flowed away, together with several ounces of white coagulated lymph, in shreds and masses. Now pass-

ing into the abdomen my right hand, I discovered the breech and legs of a large child presenting at the pelvis; and by the unoccupied hand placed outside of the abdomen I could distinctly feel the head near the ensiform cartilage. Seizing the feet, I extracted the child, and removed all the fluid and lymph contained within the abdominal cavity.

From the navel of the child the umbilical cord ran and attached itself to the peritoneal surface at the left iliac fossa. It was severed near the peritoneum, and the child removed.

I now lifted the abdominal walls and examined the empty cavity of the abdomen. Nowhere could any viscus be discovered, except at the pelvic brim where the uterus could be seen anteverted, and fixed by a copious deposit of lymph. The intestines, pressed aside and backwards, were everywhere similarly covered and bound down. A large, empty cavity, extending from the diaphragm above to the true pelvis below, presented itself to the view of my associates and myself. The placenta could not be seen, although the attachment of the cord showed where it must necessarily have been.

In a case of tubal pregnancy, in which I removed the fetus by cutting through the vagina, about a year before this, I very nearly lost my patient from hemorrhage in consequence of an effort to deliver the placenta. This determined me to be very guarded as to any similar attempt here. Another fact which prompted such a conservative course was this: in removing the fetus in Mrs. R.'s case, I had scratched the peritoneum, over the promontory of the sacrum, very slightly with my finger nail, and this wound bled so very freely and persistently as to offer me a foretaste of what would have occurred had I endeavored to remove the placenta. The decision of this point constituted, I feel, a crucial one in the operation. The delay, exposure of the peritoneal cavity, tax upon the nervous system, and loss of blood, would, I think, have decided the progress of the case adversely.

The placenta was left alone, a large glass drainage tube placed in the lower extremity of the incision, and this was closed by silver sutures involving the hypertrophied peritoneum. The operation, which, including closure of the abdominal wound, was completed in twenty-two minutes, being concluded, the patient was put to bed, quieted by opium hypodermically administered, and sustained by milk.

The child was found to be a finely developed girl, thickly covered with *vernix caseosa*, not decomposed, measuring eighteen and a half inches in length, and weighing seven pounds. The cause of its death, which had evidently occurred some time before I was consulted, was quite evident. About its middle the funis was so tightly wrapped by a long hair, which was wound repeatedly round and round it, that its circulation was completely cut off.

After the operation, the temperature and pulse both subsided, the former from 102° to 98.9° , and the latter from 120 to 107. A source of constitutional irritation and toxemia had been removed, and its evil result upon the nervous system went with it.

I shall not detain the Society with a day-to-day record of progress, but merely stop to mention two important facts, and then conclude. After the operation, the patient was placed by me under the charge of Dr. S. B. Jones, who reported her as doing surprisingly well until the fourteenth day. Until this time a spontaneous drainage of sero-pus occurred through the tube, the bowels acted daily, pulse and temperature were satisfactory, and it was thought that all danger was past. On the night of the 24th of May, however, she had a slight chill, which was followed by high febrile action. The temperature went up to 104° , and the pulse to 130, and septicemia seemed imminent. I saw her about two o'clock in the night, with Dr. Jones, and passing my finger deeply down into the abdomen, dislodged a mass of loose, very fetid blood, which was washed out by a stream of warm carbolized water projected through the drainage tube, or rather through the opening which its presence had kept patent. These antiseptic injections were kept up by

Dr. Jones every eight hours, until after forty-eight hours all evidence of danger had subsided.

Still, as the placenta was retained, the abdominal wound was at one point kept open by the glass drainage tube. Time proved the propriety of this course. Five weeks after the operation, just as we had decided to venture upon complete closure, Dr. Jones was sent for in great haste, and found a small portion of fetid placenta protruding through the abdominal opening. This he seized, and by gentle rotation removed the whole.

After this the patient rapidly recovered, very soon left her bed, and now presents an appearance of such perfect health that, upon a recent visit to my office, I did not recognize her.

One or two points in connection with this case are worthy of special note, and I draw attention to them as they may prove of value to future operators :—

1st. I believe that had a positive diagnosis not been made before operation, the case would have ended fatally when the peritoneum was reached by the primary incision. Had it been supposed that an ovarian tumor presented itself, the peeling off of this from the abdominal walls, which would have been very easily accomplished, would likely have resulted in peritoneal sloughing and death.

2d. Had an effort at removal of the placenta been made, I think that, for reasons already assigned, disastrous consequences would have ensued.

3d. Had the abdominal wound been allowed to close, by first intention, I think that the imprisonment of a putrid placenta would inevitably have created septic poisoning, with its unfortunate train of consequences.

My experience in this accident now extends to seven cases seen and examined before rupture of the extra-uterine cyst. Several others I have seen after such rupture, but these do not concern the present topic. In these seven cases a diagnosis was made early, and with certainty in every instance except one, in which it was made, but not with absolute certainty.

One of these, seen with the late Dr. W. T. Walker, recovered, the cyst discharging per rectum; another attended with Dr. Olcott, of Brooklyn, recovered after the same process; in two, one presenting at my clinic, and one attended with the late Dr. Henschel, death resulted after withdrawal of the liquor amnii by the aspirator; in one case, seen in consultation with Drs. Peaslee and Janvrin (this being that in which the diagnosis was not made with positiveness) death resulted from septicemia, after discharge of the cyst by the rectum; in one case, recovery followed removal of the fetus by elytotomy; and the seventh case is that just reported.

Thus, out of seven cases diagnosticated previous to rupture, three being left to nature, and four being operated upon, four recovered and three died. I would remark, however, that these statistics, like all others in medicine, are very likely to mislead. So much depends upon the condition of the patient, and the prognosis of the case at the time of interference, that it is unsafe to rely merely upon the display made by results, as shown in figures.

From the experience here recorded, I would offer the following suggestions for the management of these cases:—

1st. No general rule can be given as to the propriety of a resort to surgery in extra-uterine pregnancy. In a certain number of cases, as I have elsewhere stated in this paper, interference would be a blunder; in others, non-interference would be tantamount to a sacrifice of the patient's life. The indications developing in each individual case should be the guide to practice.

2d. I would recommend, after operation, that the placenta be not manually removed, but be left to nature's efforts at expulsion.

3d. The placenta being left in situ, it follows as a corollary that the external wound should be kept open to permit of its escape.

4th. Antiseptic injections into the emptied sac should be resorted to as soon as evidences of septicemia appear.



